DESIGN BRIEFING SYSTEM
NOTEBOOK

DBS 21

MC0315

Maternity Department

DEPARTMENT OF HEALTH AND THE WELSH OFFICE

Design Briefing System

Maternity Department

This Design Briefing System (DBS) document should be used in conjunction with Health Building Note No. 21, Maternity Department. It is essentially a notebook for recording decisions at project team meetings when formulating user requirements for a design brief. All members of the project team will require their own copies.

Copies of DBS documents are published with each Health Building Note and are available from HMSO bookshops and agents (see Yellow Pages) or through any good bookshop. In case of difficulty write to:

HMSO Books (P9D)
St. Crispins, Duke Street
NORWICH, NR3 1PD

Further information on the use of DBS can be obtained from:

Department of Health
Room 503, Euston Tower
LONDON, NW1 3DN

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Design Briefing System

1. The preparation of design briefs for health buildings can be simplified by using this notebook. It will help project teams to identify user requirements in a logical, considered manner.

What DBS provides

2. DBS adopts a disciplined check list approach, identifying the planning decisions which need to be made by the project team. The format of DBS is as follows: a portion of the text of the associated Health Building Note is reproduced on the left hand page. On the facing right hand page, a sequence of options implied by the text are set out in such a way that they may easily be marked for acceptance, modification or rejection. The use of DBS ensures that, for example:

a. in a sequence of decisions, none is overlooked;

b. other options may be added if necessary;

c. earlier decisions are indentified so that they may easily be recaptured when associated topics are under consideration;

d. during refinement of the brief, the implications of modifications which may affect and therefore prompt reconsideration of earlier decisions, may easily be checked;

e. members of the team can review the questions next due for consideration and thus ensure that they are fully informed before the meeting. This has been found to be of great organisational and psychological benefit;

f. members of the project team can make their own record of decisions in the notebook itself mostly by ticking options, or entering additional text in the appropriate place. This means that there is a clear, up-to-date record of agreed decisions which can easily be identified, as they are not embedded in a mass of minutes not of immediate relevance. The brief is then typed directly from a Master DBS notebook, supplemented where necessary with information from project team minutes.

3. Using DBS encourages project teams to consider the compatibility of decisions in a systematic and logical manner, thereby preparing a brief containing adequate detail of the user requirements. This should help to improve those areas in which some past designs have been deficient. For example, the provision of inadequate access or space.

4. DBS is primarily concerned with the detailed briefing stage of a project - preparation of the client/user contribution to a comprehensive design brief. In addition to providing information to the designer, the brief is useful at the commissioning stage, and for evaluation when the building has been in use for a period.

5. The use of DBS enables client/user requirements to be stated clearly and concisely by the project team, not only in respect of accommodation, but also how that accommodation is to be used. Furthermore, as mentioned previously, during refinement of the brief, use of DBS enables a check to be made on the implications of modifications resulting from previous client/user decisions, that is, it establishes a systematic data chain which can be referred to if at some subsequent stage it is necessary to trace back the reason for decisions. It must be borne in mind, however, that DBS options are not costed, and while providing the cost planner with earlier and more detailed information regarding the client/user requirements, DBS in itself does not assist in matching these with the money available.

6. This notebook is intended to be used as an aide memoire in conjunction with the associated Health Building Note and other guidance issued by the Department, and should not be regarded as taking the place of such guidance.

How to use this notebook

Using the notebook effectively

7. There are two parts to the notebook. The first part requires decision to be taken, lists the options available, and includes extracts of relevant guidance from the Health Building Note. The second part lists activity spaces (or rooms) from which a selection can be made based on decisions recorded in the first part.

Flexible use

8. Above all, the system should be used flexibly. Although the notebook anticipates the planning decisions which need to be considered, and carefully phrases the choices so that the design brief can be prepared directly from it, the project team can add other decisions, options, and notes, or change the phrasing of existing ones to suit the project's requirements.

Distribution

9. A copy of the notebook should be given to each member of the project team well before the first meeting where it is to be used. A Master copy should be held by the project team secretary to record agreed decisions from which the brief is prepared.

Planning the meetings

10. Each member of the project team should read their copy of the DBS notebook, and the associated Health Building Note, before the first planning meeting. This gives an overall view of the planning decisions which have to be made and helps to place the sequence of the decisions discussed at meetings in the right context. The notebook can be used also, especially by the secretary or chairman of the team, to prepare the agenda of meetings and to arrange in advance for the attendance (or at least the views to be obtained) of representatives of specialist users (eg dentists, pharmacists, domestic services manager) when a particular service is being discussed.

Between meetings

11. Individual project team members can be assigned tasks relating to specific parts of the notebook to consider between meetings. This feature can be used to obtain relevant information, to stimulate and focus attention on necessary fact- finding studies. It also highlights groups of decisions for members to work on, individually or in consultation with colleagues or other specialists.

Member's record of meetings

12. Each member of the project team should record in their own notebook the decisions agreed at meeting so that:

a. a clear, immediate record of agreed decisions is taken away from each project meeting, rather than having to wait for meeting minutes (which have not been confirmed and may not always reflect accurately the decisions made);

b. one continuous record of up-to-date decisions is held by each team member rather than having records of decisions taken (and often revised) at various times embedded in a series of minutes (which may, in turn, be inaccurate).

13. This feature is especially important (at or outside the project meetings) when considering decisions which may have been amended by decisions made previously, and when checking that any interim or draft design brief accurately reflect the latest agreed decisions. If members are absent from a particular meeting then arrangements must be made for them to update their own notebook.

Meeting minutes

14. Minutes need only concentrate on the background leading up to the decisions made (and recorded in the DBS notebook) at project team meetings. If it is decided that parts of the minutes should be included in the client brief as supporting information, a note should be made alongside the relevant parts of the minutes which are to be added to the brief.

Cross-referencing

15. This is explained in detail in paragraphs 26. It enables decisions to be cross-checked and is an important feature especially in helping to review the implications of revising decisions made at previous meetings.

Design brief content

16. The primary aim of the brief prepared from a DBS notebook is to record the client/user requirements for a health building. The brief should be as unequivocal as possible to enable the design team to interpret their requirements into a design.

17. In addition, the brief will contain background information for designers and provide the basis for the commissioning and evaluation of the building. The organisational decisions included in DBS notebooks form an important aspect of this. The project team may decide also to include some extra background information from meeting minutes and this should be carefully noted in the Master DBS notebook.

18. Any brief (whether interim or complete) should be prepared directly from the Master DBS notebook (with supporting parts of minutes included as notes). This helps to ensure that the draft is as up-to-date and as complete as possible. It is also easier for all members of the team to check its accuracy. The draft can then be agreed and edited before issue outside the project team.

An example of part of a brief typed from one page of a DBS notebook is reproduced as an appendix.

Preparation of Part 2

19. Part 1 should be complete before selecting the detailed accommodation required (activity spaces) in Part 2. The secretary or chairman of the team can use Part 2 to ensure that a thorough check is carried out of the detailed implications of planning decisions recorded in Part 1. The choice of activity spaces and data sheets in draft form can then be made by a small sub group of the planning team for subsequent ratification by the full team.

Use after the brief is prepared

20. The Master copy of this completed notebook should be retained (and kept up-to-date with all changes) as part of the project documentation after the design brief has been agreed, so that:

a. any subsequent changes in the brief or design which may be necessary during the project design stage can be fully checked out for their implications using the cross-referencing features of the DBS notebook;

b. it forms the basis for preparing operational manuals, initialising training programmes, etc during commissioning;

c. a true evaluation can be made between the completed building and the intentions recorded in the design brief.

d. when considering any future building changes, upgrading or project phases, this DBS notebook (together with any other DBS documents for the project) is readily available to help ensure that new planning decisions are compatible with existing accommodation that has already been planned (but not yet built).

Content

21. The planning decisions in notebooks are structured as follows:

a. *General Philosophy and Considerations*, which is a summary of general philosophy of the service provided and general points that require consideration;

b. *Scope of Service and Workload*, which sets out the scope of service provided and its workload;

c. *Locational Relationships*, with other areas of the hospital;

d. *Organisation of Service*, which sets out detailed operational policy decisions under several subheadings. Planning decisions in this section have a direct implication on one or more of the following:

(i) Design, ie affect and type and quantity of the detailed facilities to be provided;

(ii) Operational policy, ie state operational procedures or staffing decisions which can be used as a reference point for commissioning or evaluation.

e. *General Design Requirements*, which state any overriding requirements which are not specified elsewhere in the design brief.

Presentation of information

22. Except for the introductory section - General Philosophy - all sections of the DBS notebook contain a set of options/planning decisions (shown on the right hand pages) together with extracts of any relevant planning guidance material (shown on the left hand pages), opposite the appropriate options/decisions.

Guidance

23. The primary objective of the portions of guidance material on the left hand page is to remind the project team of the appropriate section of the Health Building Note which must be taken into account before specific options on the opposite page are selected.

24. Paragraphs of guidance dealing with cost effectiveness are highlighted in bold type, to alert the project team to the capital and running cost implications of certain decisions.

Planning decisions

25. For most planning decisions a set of possible options is shown. Some of these may be predetermined, for example where compatibility with whole hospital policies provides no alternatives. The project team select the appropriate option by ticking within the square brackets alongside. Where appropriate their choice can be quantified, or they can enter other decisions, options of further information to be included in the brief.

26. A simple referencing system is incorporated which allows cross-checking for compatibility of decisions made. The reference relates to the page No (top left-hand corner) and the 'REF' column letter. For example, on page 20 of this notebook 'Maternity Department', under reference 'C' - Baby feeds will be prepared: (a) by bulk preparation-commercial; the unique reference for this option if selected is 20C(a), to which can be added the generic code for the DBS document - 'MAT', making in all MAT20C(a)

27. The reference in the 'EARLIER DECISION' columns (which are already printed in the document) may be used in a number of ways:

a. to check when making a decision that previous decisions are compatible;

b. to check all the relevant consequences of doing so when proposing to change a decision.

DEFINITION

MATERNITY DEPARTMENT

This refers to the whole of the provision for maternity and neonatal services within the DGH which may also include peripheral clinic provision.

REFERENCES

Health Building Note 21: Maternity Department

The reply to the Second Report from the Social Services Committee on Perinatal and Neonatal Mortality (issued in December 1980)

Three reports of the Maternity Services Advisory Committee (MSAC):-

"Maternity Care in Action"

Part I	-	Antenatal care (September 1982)
Part II	-	Care During Childbirth (Intrapartum Care) issued with DHSS letter DA(84)4 on 30th January 1984
Part III	-	Care of the Mother and Baby (Postnatal and Neonatal Care) issued with DHSS letter DA(85)4 in February 1985

GENERAL PHILOSOPHY

The main objective of the service is to secure the safety of childbirth for both mother and child, and to provide for their care in a pleasant environment. The aim is to:

- promote good physical and mental health;
- ensure, so far as possible, the birth of a mature, live healthy infant;
- prepare the mother for labour, delivery and for the care and feeding of her child;
- detect and treat all conditions which may endanger or affect the future health of the mother and baby;
- cope with all emergencies that may arise during the antenatal, labour and postnatal period;
- try to ensure that the birth of the baby is as emotionally satisfying as possible for the mother; and also a pleasurable experience for the father and family.

Close co-operation and co-ordination of primary care and specialist services are an essential feature of good maternity care. The accommodation for mothers and babies should provide facilities for a comprehensive hospital service, closely linked with primary care carried out in the woman's own home, general practitioner surgery, health centre or other community clinics. Close multi-disciplinary co-operation involving doctors, midwives, health visitors and social workers is important in ensuring as satisfactory an outcome as possible to the pregnancy.
(HBN 21, paras. 2.1 and 2.2)

2 SCOPE OF SERVICE AND WORKLOAD

The maternity department which is on the DGH site should be dependent on the DGH for all facilities and provisions not exclusively required for maternity (including neonatal) work.

Siting of the maternity unit

The consultant maternity unit should be part of the main District General Hospital and sited so that the facilities and servides of the Department of Anaesthetics, Paediatrics, Pathology, Radiology and Pharmacy are readily available. The delivery suite should be close to the antenatal wards and facilities for the care of the newborn.

Ideally GP maternity facilities should be integral or adjacent to consultant units. In some localities, however, geographic factors will require the continued availability of GP units distant from the consultant unit.
(MSAC II, paras. 8.2 and 8.3)

The pressure on clinics

During the last two decades increasing public and professional expectations of the maternity services have led to a relatively uncritical expension of hospital antenatal clinics and associated services. Critical appraisal of the function of antenatal clinics, particularly those in the hospital, and the roles of the various health care professionals involved is overdue. The obstetrician is a scarce resource; the skills of the consultant team should be devoted primarily to the care of those women in greatest need of specialist advice.
(MSAC I, para. 1.5)

Access to other services within the hospital

Wherever possible, antenatal pathology and pharmacy services, obstetric ultrasound facilities and social work support should be provided in or adjacent to the antenatal clinic. Prescriptions should be valid for collection at the hospital pharmacy during or immediately after the clinic. Clear signposting to all departments is essential.
(MSAC I, para. 5.2)

Reduction of waiting times

The organisation of a hospital antenatal clinic is a complex undertaking. The organisers need to recognise that time is valuable to the women attending as well as to the staff, and waiting times before and between procedures should be kept to the minimum. The timing of appointments should have regard to her travel arrangements, and should be realistic in estimating the likely duration of each consultation. Appointment systems should be substituted where block bookings cause long waiting periods. Where the public transport system dictates that many of the women arrive together the aim should be to use their time productively.

Even when clinic attendances are reduced to the essential minimum there may be such a deficiency of clinic sessions or of space that overcrowding still occurs. It is the responsibility of the health authority to ensure that its allocation of clinic facilities takes full account of the need to eliminate overcrowding and to reduce to the minimum the delays for women who attend the clinics.
(MSAC I, paras. 5.3 and 5.4)

Earlier decision | Ref | 2 SCOPE OF SERVICE AND WORKLOAD

A The maternity department will be:
(a) attached as a wing to the main district hospital [ ]
(b) wholly integrated within the main district hospital [ ]
(c)

B The maternity outpatient suite will be used for the following purposes:

	No. of clinic sessions per week
(a) antenatal first visits	
(b) antenatal return visits	
(c) ultrasound	
(d) education for parenthood	
(e) special obstetric/medical (eg diabetic)	
(f) postnatal	
(g) family planning	
(h) neonatal follow-up	
(j)	
Total	

C The average attendance per session will be _____

D The peak attendance per session will be _____

2 SCOPE OF SERVICE AND WORKLOAD (contd)

PLEASE REFER TO THE POLICY STATEMENT IN MSAC III, PARAS. 4.1 AND 4.2 FOR SERVICES FOR SMALL AND ILL BABIES

Accommodation

A mother with a condition which requires specialist treatment should be cared for within the maternity unit unless intensive care facilities or other specialist care are essential.
(MSAC III, para. 3.10)

Provision of intensive care

Within each region there will be a need for one or more designated Regional Perinatal Centres, able to maintain care for the mother and intensive care for the baby for long periods. Mothers can be referred antenatally to such units when the birth of a baby who is likely to require long term intensive care is anticipated. All but the smallest maternity units should have their own neonatal unit with staff able to initiate intensive care for very small and ill babies whenever required, and to maintain such care at least until the baby can be transferred to a unit with the necessary facilities.

The function of Regional Perinatal Centres should be to provide the necessary back-up to Districts and to take the lead in training medical and nursing staff in the high level of expertise required and in research directed towards advancing standards and effectiveness of perinatal care.

A Regional policy of total centralisation of neonatal intensive care in Regional Perinatal Centres is not recommended. This creates difficulties in maintaining family links. District neonatal units need moreover to develop in parallel with Regional Centres their ability to provide some intensive care because anticipation, prompt recognition and early intervention in neonatal disorders may prevent deterioration and so will minimise the need to transfer the baby elsewhere.
(MSAC III, paras. 4.4, 4.5 and 4.6)

The neonatal unit

The term 'neonatal unit' is used to describe any area designated for small or ill babies who cannot be cared for with their mothers in the areas for postnatal care. All babies needing intensive care will be admitted to such a unit, together with a proportion of those needing special care. As staffing levels and expertise build up however, more babies can be expected to receive appropriate forms of special care not in the unit, but with their mothers in the postnatal areas. The extent of the need for special care in neonatal units will depend on the one hand on the ability to care for babies in the postnatal area, and on the other on the number of babies who progress to special care from intensive care.
(MSAC III, para. 4.3)

Neonatal units for small and ill babies

An area within the DGH maternity department should be designated for neonatal intensive care and/or for special care for those babies not able to be cared for alongside their mothers.

Most DGHs will be expected to provide a measure of intensive care as facilities and expertise develop outwards from the Regional Perinatal Centres. If a maternity department has no long-term intensive care facilities, certain babies will need to be transferred to Regional Perinatal Centres or other specialised units.
(HBN 21, para. 2.22)

Provision for neonatal surgery

The Regional strategy should include provision for neonatal surgery. Babies requiring immediate surgery to correct a life threatening condition should be admitted without delay to a special neonatal surgical unit. Ideally, such facilities should be sited within Regional Perinatal Centres. There should be at least one such unit in each Region able to provide continuous care and supervision of the baby by medical and nursing staff before and after the operation, although for neonatal cardiac surgery referral may have to be to a designated Supra-Regional Centre. (MSAC III, para. 4.10)

Earlier decision | Ref | 2 SCOPE OF SERVICE AND WORKLOAD (contd.)

A Operating theatre facilities will be available:
(a) in the delivery suite [ ]
(b)

B Mothers requiring intensive or specialised medical care will be cared for in:
(a) the maternity unit [ ]
(b) the DGH [ ]
(c)

C Babies requiring intensive neonatal care will be cared for:
(a) in the neonatal unit [ ]
(b) by short term support, then transferred elsewhere and returned for subsequent care [ ]
(c)

D Babies requiring neonatal surgery will be cared for in:
(a) the neonatal unit [ ]
(b) the paediatric department [ ]
(c) another hospital (SPECIFY) _____
(d)

E A segregated nursing area will be required for:
(a) mothers with infections, with or without babies [ ]
(b) babies with infections, accompanied by their mothers [ ]
(c) babies with infections [ ]
(d)

F Cases of major infection, where the infection takes precedence over the obstetric condition, will be nursed in:
(a) an isolation unit [ ]
(b)

2 SCOPE OF SERVICE AND WORKLOAD (contd)

Undergraduate Medical Students

If it has been agreed that the teaching of undergraduate medical students will take place in the accommodation, and their numbers necessitate additional space, this should be provided as part of the overall requirements for the department. Reference should be made to the Department's letter DS 65/74 about teaching hospital space requirements, issued on 22 March 1974, and letter DS 86/74 dated 27 March 1974. (In Wales, reference should be made to letter HSD 3/57/1 dated 29 April 1974).
(HBN 21, para. 5.22)

Postgraduate Medical Education

Although some education requiring special facilities will take place in the district's education centre, some teaching has to take place in the department. Apart from the use of seminar rooms, no special facilities are normally required elsewhere in the hospital.
(HBN 21, para. 5.23)

Nurse and Midwife Education

All districts undertake nurse and midwife education, and most have the approval of the statutory body to conduct qualifying courses. As qualifying and formal post-basic courses are largely clinically based, officers of the statutory body visit teaching accommodation and clinical areas to monitor facilities and practice, and the volume and range of work.

In clinical areas seminar rooms are required at ward or unit level. In addition an office base for the midwife/clinical teacher is required. Theoretical elements of courses will be undertaken in the nurse and midwife education component of the education centre, or the school(s) of nursing and midwifery.

If satellite educational accommodation is required such as teaching accommodation for midwifery education in a maternity unit, then the requirements should be determined using the methodology described in "Accommodation for Education and Training" in HBN 42 (in preparation). This accommodation would be included when assessing the District's total requirements for education accommodation.
(HBN 21, para. 5.24)

Other Staff

The requirements of students in professions other than medicine and midwifery and the trained staff will need to be taken into account, and the appropriate people and/or bodies should be consulted at the initial planning stages.
(HBN 21, para. 5.25)

Earlier decision | Ref | 2 SCOPE OF SERVICE AND WORKLOAD (contd.)

A Educational facilities will be provided in the department for:
(a) midwifery training [ ]
(b) maternity care experience for nurse learners [ ]
(c) in-service/midwifery refresher/post-basic midwifery courses [ ]
(d) ENB clinical courses (SPECIFY) _____

_____

_____

_____

(e) medical students - obstetric, paediatric [ ]
(f) postgraduate training for GPs and other medical staff [ ]
2B (g) maternity department clinical meetings/seminars [ ]
(h) parents [ ]
(j)

B Additional teaching accommodation will be available in:
(a) the hospital education centre [ ]
(b) the midwifery training school [ ]
(c) the DHA community premises [ ]
(d) another health district (SPECIFY) _____

_____

(e) centres of further and higher education (SPECIFY)

_____

_____

(f) postgraduate medical centre [ ]
(g)

3 LOCATIONAL RELATIONSHIPS WITH OTHER AREAS OF THE HOSPITAL

The Maternity Department: its location in relation to other parts of the DGH

There are many advantages, such as accessibility of diagnostic and treatment facilities and services like catering and supplies, in integrating the maternity department into the body of the DGH.

Where a maternity department is being added to an existing hospital, integration may be unrealisable, but even so, every attempt should be made to locate the wards to maximise flexibility in use. In an integrated department, it is the interior design and furnishing that will most effectively proclaim that the women are not sick.

Maternity wards (both antenatal and postnatal) which are by far the largest element in the department, have in the past often had low occupancy due to variations in birthrate and reduction in length of stay. If they are sited so that some of them could be transferred for use by gynaecological or other medical or surgical specialities, a much higher degree of long term overall utilisation can be achieved.

The maternity department needs to be located with easy access of the main diagnostic areas of the District, especially the radiological services, pharmacy, pathology and anaesthetic services. The maternity department should also be within easy access of the paediatric unit and the social work services department.
(HBN 21, paras. 2.4, 2.5, 2.6 and 2.7)

Planning Considerations

The maternity outpatient suite should be designed so that it has an identity of its own and can function independently from the general hospital outpatients department.

The suite should be on the ground floor and be well signposted. It should be within easy reach of the delivery suite and the maternity wards. The relationship to other hospital departments must be carefully considered, of particular importance are the Social Work Services Department, the Radiodiagnostic Department, where many women may go for their ultrasound examinations, the pharmacy and pathology department. Both the forward and reverse routes should be clearly marked.
(HBN 21, para. 3.5)

Earlier decision	Ref	3 LOCATIONAL RELATIONSHIPS WITH OTHER AREAS OF THE HOSPITAL
	A	Access to the parent hospital will be: (a) via a covered corridor [ ] (b)
	B	The maternity department (within the main hospital building) will: (a) form a discrete area by a horizontal relationship [ ] (b) form a discrete area by a vertical relationship [ ] (c)
2A	C	The maternity outpatient suite will be associated with the: (a) main outpatient department [ ] (b) maternity department [ ] (c)
	D	The maternity wards will be associated with the: (a) maternity outpatient suite [ ] (b) neonatal unit [ ] (c) delivery suite [ ] (d)
	E	Reasonable access will be required between the: (a) central delivery suite and the main operating theatre suite [ ] (b) neonatal unit and the paediatric unit [ ] (c) neonatal unit and postnatal wards [ ]
4A,B		(d) maternity department and the education centre [ ] (e)
	F	The order of priority for planning the maternity department near other areas of the hospital are: (INDICATE PRIORITIES IN NUMERICAL ORDER) (a) ground floor external access [ ] (b) diagnostic imaging services [ ] (c) outpatients department [ ] (d) operating department/anaesthesia services [ ] (e) paediatric unit [ ] (f) pathology services [ ] (g) pharmacy [ ] (h) social workers' office [ ] (j) supplies/catering [ ] (k) intensive therapy unit [ ] (m) isolation unit [ ] (n) coronary care unit [ ] (p) (q) (r)

4 BED AND DELIVERY SUITE

Service Planning

Over 98% of births now take place in hospital. Planning of the District Maternity Services should therefore provide for all women who may wish to be delivered in a fully equipped DGH offering the full range of maternity services. In these maternity units in-patient beds and delivery suites should be available, subject to local agreement, to women in the care of general practitioners, midwives and consultant obstetric staff. The District planning of maternity provision should take into account local factors and be based upon a statistical analysis of needs.

The length of time spent by the women in the delivery room depends not only on the length of labour but also on factors such as induction policy, occurrences of complicated labour, and the need for observation of mothers recovering from an operative procedure. Other factors that will influence bed occupancy are the availability of staff to move the women and domestic staff to clean rooms between deliveries etc. On the assumption that an average of 24 hours per patient in a delivery room is required, because a delivery bed must always be available and the admission of patients in labour occurs irregularly, a 75% occupancy rate should be used to assess the number of rooms to be provided for the predicted number of births.
(HBN 21, paras. 2.8 and 2.13)

Abnormal Delivery Suite

It must be possible to perform operative obstetric procedures including Caesarean Sections in the delivery suite. There are several ways the facilities may be provided. One common method is for there to be two abnormal delivery rooms, both equipped as obstetric theatres, one normally set up for vaginal deliveries on the obstetric bed, the other set up for abnormal deliveries on an operating table. See paragraphs 3.63, 3.64 and Appendix 2: Ergonomic drawings.
(HBN 21, para. 2.14)

Inpatient Beds

Future bed needs are difficult to predict because of a number of variable factors. As general indicators, planning teams are given the following factors for guidance in assessing the estimated number of beds needed:

a. the estimated number of women of child-bearing years in the District served by the department: this is only a rough indicator due to trends in family planning and sterilisation;

b. the local birth rate;

c. the average length of stay - local factors should be considered carefully;

d. the realistic percentage bed occupancy to be aimed for - this is about 75%.

It must be stressed that each health authority needs to reach its own decision on the number of beds required locally.
(HBN 21, para. 2.15)

Neonatal Units

The guidance in paragraphs 2.17 to 2.22 takes account of the advice on good practice in the care of the newborn, which is given in Chapter 4 of the Maternity Services Advisory Committee's third report "Care of the Mother and Baby" (issued with letter DA(85)4 dated February 1985). Planners are encouraged to study that Chapter in relation to neonatal units.
(HBN 21, para. 2.16)

Earlier decision | Ref | 4 BED AND DELIVERY SUITE

A The population of the area (for planning purposes) is estimated will be:

	19__	19__
(a)	____	____

B Of these the estimated number of females aged 15-44 will be:

	19__	19__
(a)	____	____

C Provision will be needed per year for:

		19__	19__
	(a) deliveries	____	____
	(b) babies needing additional care	____	____
3C-F	(c) babies needing special care	____	____
	(d) babies needing intensive care	____	____
	(e)	____	____

D A summary of bed provision required is as follows:

		No. of bed/cots
	(a) antenatal/postnatal	____
3B	(b) antenatal/postnatal high dependency	____
3E	(c) antenatal/postnatal barrier nursing	____
	(d) delivery rooms (including assessment)	____
	(e) abnormal delivery room	____
3A	(f) operating theatre	____
	(g) neonatal unit cots	____
	(h) parents suite in neonatal unit	____
	(j) antenatal day care area	____
	(k)	____
	(m)	____
	Total bed/cots	____

Earlier decision | Ref

5 ORGANISATION OF SERVICE

5.1 PATIENT RECEPTION AND DOCUMENTATION

A The system of patient registration will be:
(a) pre-registration [ ]
(b) registration at first attendance [ ]
(c) using a computer terminal [ ]
(d) with records compiled in the records department [ ]
(e)

B Women attending for the first antenatal visit will register:
(a) at home [ ]
(b) at G.P. premises/health centres [ ]
(c) centrally outside the department [ ]
(d) at reception in the department [ ]
(e)

2B C Women attending for return antenatal visits will report:
(a) at reception in the maternity department [ ]
(b) at a reception point in the maternity outpatient suite [ ]
(c)

D Women will attend the maternity outpatient suite by:
(a) G.P. referral [ ]
(b) referral from another department [ ]
(c) 'walk-in' [ ]
(d) other referral (SPECIFY) _____
(e)

6 E Pattern of return antenatal visits will be for (SPECIFY):

	No. of visits
(a) uncomplicated cases	_____
(b) complicated cases	_____
(c) ultrasound examination	_____
(d) parentcraft	_____
(e) laboratory tests	_____
(f) special tests	_____
(g)	

Policy statement

Complications during pregnancy, especially if they require antenatal admission to hospital, can be particularly stressful for a mother and her family. The doctor and midwife should take time to discuss with the mother the nature of the problem and try to alleviate her anxieties. In recommending a type of care they should consider her basic needs as a pregnant woman as well as the condition that calls for special treatment. For some women, a period of close supervision at home might be an appropriate and preferable alternative to a stay in hospital.
(MSAC II, para. 5.1)

The accommodation of mothers requiring antenatal admission

A mother admitted to hospital with antenatal complications should be looked after apart from any women admitted for the termination of their pregnancy.

Mothers who are likely to be in hospital for a long time should be accommodated apart from mothers admitted in an emergency or for a short antenatal stay.
(MSAC II, paras. 5.2 and 5.5)

Preparation for admission

Every mother should be told well in advance how to recognise the early symptoms and signs of labour and what she should do when they occur. She should have the telephone number of the maternity unit and written instructions, in a language she understands, on how to get there and on any special arrangements for night admissions.
(MSAC II, para. 2.12)

The baby's records

Every baby born in hospital should be allocated a hospital index number, and have his own records folder initiated by the doctor or midwife who attended the birth, before the mother and baby leave the delivery suite. The baby's and mother's notes should be cross-referenced. The baby's sex, birthweight and head circumference should be recorded together with any additional measurements taken.
(MSAC III, para. 2.6)

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.1 PATIENT RECEPTION AND DOCUMENTATION (Contd.)

A Women will be admitted to the maternity department:
(a) from home as booked or emergency antenatal admission [ ]
(b) from home in labour [ ]
(c) from the accident and emergency department [ ]
(d) from another department of the hospital [ ]
(e) by G.P. or midwife referral [ ]
(f) from another hospital [ ]
(g)

B Women for elective admission will be admitted to the maternity department:
(a) via the patient services department [ ]
(b) direct to the appropriate ward [ ]
(c)

C Babies born outside the hospital will be admitted to the
(a) postnatal ward [ ]
(b) neonatal ward [ ]
(c) neonatal surgical ward [ ]
(d) paediatric ward [ ]
(e)

3B, 6D D Women requiring observation for a short period, e.g. less than 24 hours, will be accommodated in:
(a) an observation bed area sited _____
(b) an emergency admission area sited _____
(c) the antenatal ward area [ ]
(d) the labour ward [ ]
(e)

E Night admissions will be directed to:
(a) the delivery suite [ ]
(b)

F Documentation for women on admission will be carried out by:
(a) _____
(b) _____

G Documentation of babies born in or brought into the maternity unit will take place in the:
(a) delivery suite [ ]
(b) postnatal ward [ ]
(c) neonatal ward [ ]
(d) neonatal surgical unit [ ]
(e) paediatric ward [ ]
(f)

Review of the plan for care during labour and initial procedures

The mother should be introduced to the midwife responsible for her care as soon as possible. Her records should be immediately available so that the midwife can check with her that they are complete and up to date, and that her individual needs and special wishes have been recorded. The midwife should take the opportunity of discussing anything that may be worrying the mother. For a mother who arrives un-announced or for whom the unit does not have adequate records staff will have to allow extra time to obtain the necessary medical history and to agree a plan for her care. The unit's operational policies should allow for such situations. (MSAC II, para. 3.3)

Earlier decision	Ref	
		5 ORGANISATION OF SERVICE 5.1 PATIENT RECEPTION AND DOCUMENTATION (contd.)
	A	Women may arrive at the ward: (a) on foot [ ] (b) in a wheelchair [ ] (c) on a trolley [ ] (d)
	B	Women may be accompanied on arrival by: (a) relatives or friends [ ] (b) ambulance personnel [ ] (c) hospital staff [ ] (d) community staff [ ] (e)
7A	C	Womens' current maternity records will be kept (during the antenatal period): (a) by them [ ] (b) in the maternity outpatient suite [ ] (c) on the delivery suite [ ] (d)
7A	D	Womens' previous maternity and relevant medical records will be kept (during the antenatal period): (a) in the medical records department [ ] (b) in the maternity outpatient suite [ ] (c) on the delivery suite [ ] (d)
	E	Medical secretary/typing facilities will be provided: (a) centrally [ ] (b) at department level [ ] (c)
	F	In-patient records for mother and/or baby will be written up: (a) at the bedside [ ] (b) at the staff base [ ] (c) in the ward, via a computer terminal [ ] (d) in the doctor's office [ ] (e)
	G	Documentation of a woman admitted unbooked will take place in the: (a) ward/department to which she is being admitted [ ] (b) central patients admission office [ ] (c) ward/department from which she is being transferred [ ] (d)

Antenatal Area

These women are admitted as a result of referrals from the maternity outpatient suite, the general practitioner or community midwife, domiciliary visits, the delivery suite or from other departments in the hospital or other hospitals. They may arrive on foot, in a wheelchair or bed or on a trolley and may be accompanied by relatives or friends. It may be the policy that some mothers will receive additional antenatal supervision and treatment on a day care basis.

The design should take into account the following needs:

i. All women need a friendly and welcoming environment;
ii. Some need quiet, some need company;
iii. Some need to be nursed in single rooms for a variety of clinical reasons;
iv. Some will be there for only a short period, some for several weeks;
v. Some will be admitted only once; some several times;
vi. Some will require regular monitoring of their own and their baby's condition;
vii. Some will go into labour in antenatal ward; (NB transfer is noisy);
viii. Some may have infections;
ix. Some need very complex nursing care; others almost none.

Postnatal Mothers and Babies

Postnatal mothers and babies will be transferred from the delivery suite, the operating theatre, other hospitals or admitted from home. Normal healthy babies and some babies requiring additional care will room-in with their mothers. Their cots should be beside the beds, not at the end of them.

Bedrooms

Facilities should be provided for the mothers to be cared for in either single or 4 to 6 bedded rooms. Care should be taken to ensure that women who are ill or highly dependent can be nursed close to the staff base.

Two of the single rooms in each ward should each have a WC, shower and bidet ensuite. In each area used for postnatal care a room should be so designed that it can, on occasions, be used as a nursery to accommodate those few babies who need to be removed temporarily from their mother's bedside. This room should have an observation window and be sited close to the staff base.

Each multi-bed room should also have a WC, shower/bathroom ensuite or adjacent so that mothers have easy access to toilet facilities.

Washing facilities with elbow action taps are required in each room. There should be adequate space below the taps to allow bowls/baby baths to be filled.
(HBN 21, paras. 3.96, 3.97, 3.98, 3.99, 3.100 and 3.103)

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.2 PATIENT CARE

3, 6D — A

Women will be grouped:
(a) for antenatal care [ ]
(b) for postnatal care [ ]
(c) by dependency [ ]
(d) by barrier nursing requirements for segregation/isolation [ ]
(e) for additional babycare [ ]
(f)

B

Physiotherapy exercises for mothers will be carried out in the:
(a) bed area [ ]
(b) ward area [ ]
(c) day area [ ]
(d)

2B — C

Parentcraft teaching will be carried out in the:
(a) bed area [ ]
(b) ward area [ ]
(c) maternity outpatient area [ ]
(d) parentcraft room [ ]
(e)

2B — D

The pattern of organisation for antenatal outpatient care will be:
(a) shared between community and hospital sites [ ]
(b) entirely in hospital [ ]
(c) entirely in community [ ]
(d) day care facilities [ ]
(e)

2B — E

The pattern of organisation for postnatal/family planning clinics will be:
(a) mainly in community setting [ ]
(b) hospital for selected cases [ ]
(c) mainly in hospital/peripheral clinics [ ]
(d) provided by hospital staff [ ]
(e) provided by G.P./community staff [ ]
(f)

F

The pattern of organisation for consulting/examination rooms in the clinics will be:
(a) the complete procedure will take place in one room (i.e. history taking, undressing, weighing, blood pressure estimation and venepuncture) [ ]
(b) some rooms will be used exclusively for specific procedures

(SPECIFY)_____

_____

(c)

Design philosophy for postnatal care

To the extent that the majority of newly delivered mothers and their babies are healthy, their care needs are different from those of hospital in-patients. They will often only stay in hospital for a short time before returning home and may need rest during this period. The need is for a friendly relaxed environment in which their babies will be with them or near them most of the time. Accommodation need not be designated for postnatal care only. The design should allow for the accommodation of both antenatal and postnatal mothers in the same area, but not within the same room.
(MSAC III, para. 9.3)

Size and design of accommodation for postnatal care

The size and design of rooms used for postnatal care should allow for the adequate supervision of mothers and babies at all times. Single rooms should be provided for mothers wishing to be alone or requiring special care or treatment, the number depending on the design of accommodation and assessment of likely needs. Shared rooms should have curtains around each bed to allow individual privacy when required. All rooms should be carpeted, suitably furnished and attractively decorated. Windows should provide adequate natural daylight and ventilation and have curtains or shades.
(MSAC III, para. 9.4)

Mothers of babies who are to be fostered or adopted

A mother who refuses all contact with her baby following his birth may still need time to come to terms with her decision. If she wishes, she should be told where and by whom her baby is being cared for and given news of his well-being prior to adoption. She should be offered counselling, if appropriate, and staff should be supportive of her whatever decision she has taken about her baby's care. Each mother should be asked whether she wishes to have a single room or to share a room with others, and her wish should be met.
(MSAC III, para. 3.14)

Earlier decision	Ref	5 ORGANISATION OF SERVICE 5.2 PATIENT CARE (contd.)
	A	Clinical laboratory facilities will be provided at ward level in the: (a) delivery suite [ ] (b) neonatal unit [ ] (c)
	B	In the follow-up clinic infants will be examined and weighed in a: (a) consulting/examination room [ ]
2B		(b) designated area [ ] (c)
6D	C	Ward nursery facilities will be used for: (a) babies who have to be temporarily removed from the mother's bedside [ ] (b) healthy babies whose mothers are unable or unwilling to care for them [ ] (c)

Bedrooms

Storage is required for the mothers' personal and hospital clothing and equipment. Mothers should have easy access to toilet articles, water jug and glass etc. from either the left or right hand side according to their needs. Babies' clothing and equipment should be stored in their trolley cot cupboard. The baby's bath/bowl may also be stored in the cot.
(HBN 21, para. 3.102)

Bedspace

Each bedspace will require:

a. An adjustable bedhead lamp with dimming facility.
b. A bedhead services panel with: outlet for patient handset; 13 amp power point; staff-to-staff emergency call and outlet for earphones.
c. A patient handset control unit incorporating patient-to-staff call; radio channel selector and a volume control for radio and TV; bedhead lamp switch with dimming position.
d. Convenient access to oxygen and piped medical vacuum which may be incorporated in the bedhead panel.
e. A suitable bed, possibly a King's Fund bed, a bedside locker (or locker wardrobe), chair and overbed table.
f. A conveniently located outlet for a telephone trolley.
g. A multi-bed room designated for mothers and babies needing additional care will require piped oxygen, compressed air and vacuum at each bedspace and extra socket outlets.

(HBN 21, para. 3.106)

Day Space

Mothers may use the day space for reading, relaxation, watching television, receiving visitors and recreational purposes. Because of the practice of early ambulation following delivery the majority of mothers will not be confined to bed. Day rooms provide a change of environment, a place to meet fathers, relatives and their other children, or to meet mothers from other bedrooms and enjoy a relaxed setting.

The designer should aim to create an environment which is cheerful, comfortable and warm. Appropriate lighting and decorative features such as pictures and plants can provide a tasteful domestic atmosphere. Finishes and furniture will have an important influence on the day room. A variety of easy chairs, bookcases and coffee tables should be provided.
(HBN 21, paras. 3.107 and 3.108)

Sitting Room

There should be a conveniently sited general sitting room for mothers to receive visitors. Smoking should be actively discouraged, and not permitted in areas where there are babies or which are occupied by mothers who do not smoke.
(MSAC III, para. 9.7)

Earlier decision | Ref

5 ORGANISATION OF SERVICE

5.3 FACILITIES FOR WOMEN AND BABIES

A In-patients property (SPECIFY) will be kept:

(a) at the bedside in a mobile locker _____

(b) in a wardrobe/hanging locker _____

(c) in suitcase storage _____

(d) in storage cupboards _____

(e)

B Day facilities will include:

(a) dining/sitting space in multi-bed rooms [ ]

(b) general day/dining areas for each ward [ ]

(c) general day/dining areas shared between wards [ ]

(d)

C Smoking will be:

(a) allowed in specially designated areas (SPECIFY)

_____

_____

(b)

D Sanitary facilities will be required:

(a) in each single room [ ]

(b) in selected single rooms [ ]

(c) immediately adjacent to each multi-bed room [ ]

(d) within reasonable distance of bed/day/dining areas [ ]

(e)

E Visiting hours in ante/post-natal wards will be:

(a) open [ ]

(b) limited [ ]

(c) varied [ ]

(d)

F Facilities required for relatives and escorts will include:

(a) a waiting area/room [ ]

(b) beverage facilities [ ]

(c) overnight stay facilities [ ]

(d)

G Enquiries and discussions with mothers and visitors may take place:

(a) at the bedside [ ]

(b) in any available office in the ward [ ]

(c) in an interview room [ ]

(d) in the medical social workers office [ ]

(e) at the staff base [ ]

(f)

Privacy

Privacy during examinations is essential and the women should be able to put the questions which concern her without being overheard. Examination cubicles should be separate from public areas and students and relatives should only be present if the woman gives her permission.

Wherever possible, all examinations which involve undressing should be carried out at one stage in the visit, so that women do not have to sit in public waiting areas in hospital gowns. A secure place should be provided for clothing and valuables, where the woman does not keep these with her. Arrangements for collecting urine specimens should be discreet.
(MSAC I, paras. 5.7 and 5.8)

Dirty Utility Room

A dirty utility room is required for the disposal and cleaning of clinical equipment used in the suite. Facilities are required for the disposal of liquid waste, the cleaning of dressing trolleys and the temporary holding of materials requiring reprocessing or disposal. Some shelves for limited storage are required. Facilities for urine testing should be provided within the dirty utility room. The two specimen collecting WCs should have hatches through to the test area. For patients who bring specimens with them the room should have a horizontally divided door with a counter top or a hatch to the corridor, or a table where the women can put their urine specimens.
(HBN 21, para. 3.17)

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.3 FACILITIES FOR WOMEN AND BABIES (contd.)

A The waiting area of the clinic will accommodate:
(a) women waiting for appointments [ ]
(b) escorts and relatives [ ]
(c) women waiting for examinations [ ]
(d) mothers with children [ ]
(e) those awaiting transport [ ]
(f)

B Accommodation will be provided for children (accompanying mother)[including]:
(a) nursery/play space facilities - staffed [ ]
(b) nursery/play space facilities - not staffed [ ]
(c) pram/pushchair park - inside [ ]
(d) pram/pushchair park - outside (secure area/unattended) [ ]
(e)

C Separate sub-waiting areas will be provided for:
(a) ultrasound clinics [ ]
(b)

2B, 10C

D The maternity outpatients waiting area when not in use for clinics may be used for:
(a) parentcraft teaching [ ]
(b) additional waiting space for visitors [ ]
(c) a meeting place for departmental discussions [ ]
(d) a hall for social functions [ ]
(e) educational film shows and lectures [ ]
(f)

E The need for privacy is essential in:
(a) consulting/examination areas [ ]
(b)

F The woman's clothing and valuables when undressing will be:
(a) in the consulting/examination room [ ]
(b) left in a locked cubicle [ ]
(c) kept with her [ ]
(d)

G Urine specimens will be collected and tested:
(a) in a dirty utility room, with connecting hatch to specimen collecting WC [ ]
(b)

H Women bringing specimens with them will:
(a) place them on a table [ ]
(b) hand them over a counter/hatch to the dirty utility [ ]
(c)

Earlier decision	Ref	5 ORGANISATION OF SERVICE 5.4 EDUCATION
4	A	Teaching/clinical instruction will be carried out in the department for: (a) student midwives [ ] (b) nurse learners [ ] (c) post-registration course nurses and midwives [ ] (d) student health visitors [ ] (e) medical undergraduates [ ] (f) medical post-graduates [ ] (g) physiotherapy trainees [ ] (h) housekeeping staff [ ]
2B		(j) mothers [ ]
13D		(k) relatives [ ] (m)
4	B	And this will take place: (a) at the bedside [ ]
13D		(b) at the staff base [ ] (c) in the sister/charge nurse's office [ ] (d) in a seminar room [ ] (e) in the accommodation for education and training [ ] (f) in the parentcraft room [ ] (g) in the milk kitchen [ ] (h)
4	C	Formal teaching of midwifery/nursing/medical staff will be carried out in: (a) the accommodation for education and training [ ] (b) in teaching accommodation in the department [ ] (c) in a seminar room in the department [ ] (d) in a seminar/interview/rest room in the department [ ] (e) in a seminar room at ward level [ ] (f)
	D	The person/s responsible for teaching programmes will be: (a) a midwifery tutor [ ] (b) a parentcraft teacher [ ] (c) a neonatal course tutor [ ] (d) a doctor [ ] (e)
	E	Offices will be required in the department for: (a) the midwifery tutor/s [ ] (b) neonatal course tutor [ ] (c)
2B	F	Teaching/instruction of parents will take place in: (a) bed/ward/cot area [ ]
13D		(b) maternity outpatient suite [ ] (c) parentcraft demonstration area [ ] (d) classroom/seminar room [ ] (e) neonatal unit [ ] (f) milk kitchen [ ] (g)

5 ORGANISATION OF SERVICE

5.5 STAFFING

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.5 STAFFING

A The day-to-day management of the department will be the responsibility of:
(a) a senior midwife in charge of unit [ ]
(b) senior midwife/nurse in charge of sub unit [ ]
(c) sister/charge nurse/midwife in charge of a ward [ ]
(d)

B The above staff will require offices:
(a) in the department [ ]
(b) centrally in the administration area [ ]
(c) on the ward [ ]
(d) with the exception of (SPECIFY) _____
(e)

C Office accommodation will also be required for (SPECIFY SHARED RATIO):
(a) midwifery staff _____/_____
(b) obstetric staff _____/_____
(c) social worker _____/_____
(d)

D The person clinically responsible for the individual woman attending the unit will be the:
(a) consultant in the unit [ ]
(b) referring consultant/GP [ ]
(c) referring consultant/GP for overall care and consultant in the unit for immediate supervision of care [ ]
(d) hospital/community midwife [ ]
(e)

E The estimated number of medical staff required for planning purposes will be:

	Obstetrics (WTE/sessions)	Anaesthetics (WTE/sessions)	Paediatrics (WTE/sessions)
(a) consultant	_____	_____	_____
(b) senior registrar	_____	_____	_____
(c) registrar	_____	_____	_____
(d) S.H.O.	_____	_____	_____
(e) medical assistants	_____	_____	_____
(f) clinical assistants	_____	_____	_____
(g) GP	_____	_____	_____
(h)			

5 ORGANISATION OF SERVICE
5.5 STAFFING (contd.)

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.5 STAFFING (contd)

10A — A

The method of organising care will be:
(a) team [ ]
(b) case assignment [ ]
(c) team/case assignment [ ]
(d) job assignment [ ]
(e)

B

The estimated number, for planning purposes, of nursing staff will be:

	MATERNITY			NEONATAL		
	Part-time	Full-time	WTE	Part-time	Full-time	WTE
(a) senior midwife	____	____	____	____	____	____
(b) senior nurse	____	____	____	____	____	____
(c) sister/charge nurse/ midwife	____	____	____	____	____	____
(d) registered midwives	____	____	____	____	____	____
(e) registered nurses	____	____	____	____	____	____
(f) enrolled nurses	____	____	____	____	____	____
(g) nursery nurses	____	____	____	____	____	____
(h) auxiliaries	____	____	____	____	____	____
(j) student midwives	____	____	____	____	____	____
(k) nurse learners	____	____	____	____	____	____
(m) post-basic course students	____	____	____	____	____	____
(n) liaison health visitor	____	____	____	____	____	____
(p)	____	____	____	____	____	____
TOTALS	____	____	____	____	____	____

6D — C

The ratios of midwifery/nursing staff to bed/cots estimated, for planning purposes, will be:

	Staff/beds	Staff/cots
(a) day duty	____/____	____/____
(b) night duty	____/____	____/____
(c) annual leave	____/____	____/____
(d) sick leave	____/____	____/____
(e) study leave	____/____	____/____
(f)		

D

The level of service given by learners will be:

(a) student midwives ____%
(b) nurse learners ____%
(c)

A social worker and a laboratory technician will normally attend main clinic sessions.

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.5 STAFFING (contd)

A The estimated number, for planning purposes, of paramedical staff will be:

	Part-time	Full-time	WTE sessions per _____
(a) social workers	_____	_____	_____
(b) dietician	_____	_____	_____
(c) interpreter	_____	_____	_____
(d) physiotherapist	_____	_____	_____
(e) physiotherapy helpers	_____	_____	_____
(f) laboratory technician	_____	_____	_____
(g) medical photographer	_____	_____	_____
(h)			

B Other staff requirements will be:

	Part-time	Full-time	WTE
(a) domestic assistants	_____	_____	_____
(b) cleaners	_____	_____	_____
(c) ward orderlies	_____	_____	_____
(d) porters	_____	_____	_____
(e) clerk/receptionist	_____	_____	_____
(f) secretary/typist	_____	_____	_____
(g)			

C Porters will be provided:
(a) exclusively for the department on a permanent basis
(SPECIFY AREAS IF NOT ALL INCLUDED) _____
(b) exclusively for the following areas _____
_____
(c) seconded to the department [ ]
(d) from central portering services [ ]
(e) on a 24 hour basis [ ]
(f)

D Cleaning will be carried out:
(a) partially by domestic staff working exclusively in the wards and partially by temas working outside busy periods [ ]
(b) by domestic staff working in the department only [ ]
(c) on a 24 hour basis [ ]
(d)

E A cleaner's room will be required in the:
(a) outpatients department [ ]
(b) ward/s [ ]
(c) delivery suite [ ]
(d) operating theatre [ ]
(e) neonatal unit [ ]
(f)

MATERNITY DEPARTMENT

5 ORGANISATION OF SERVICE
5.6 STAFF FACILITIES

Earlier decision	Ref	
15/16/17	A	The estimated total number of staff for planning purposes working in the department will be: (a) male _____ (b) female _____
15/16/17	B	The average number of staff working in the department during a peak period will be: (a) male _____ (b) female _____
	C	Staff using changing accommodation: (a) centrally, in hospital, local lockers only [ ] (b) in department [ ] (c) in each unit [ ] (d) in each sub-unit [ ] (e) in each ward [ ] (f) most centrally, a few in department [ ] (g)
	D	Staff will be required to wear protective or special clothing for the following clean areas: (a) normal delivery area [ ] (b) operating theatre [ ] (c) abnormal delivery area [ ] (d) neonatal unit [ ] (e) isolation/segregation [ ] (f)
14B	E	Rest room facilities will be provided in: (a) a seminar room (associated with clinical area) [ ] (b) the rest room for department [ ] (c) a rest room for the unit [ ] (d) the sister/staff nurse's office [ ] (e) outside the department (SPECIFY) _____ (f) _____
15C	F	Community midwives will be based in: (a) their own office accommodation [ ] (b) accommodation in peripheral clinics [ ] (c) their homes [ ] (d)
14B,15C	G	G.P.s, liaison health visitors, social workers will use: (a) their own office accommodation elsewhere [ ] (b) shared office accommodation within maternity unit [ ] (c) the seminar room associated with clinical areas [ ] (d) the staff rest room [ ] (e)

Bedrooms

A small sitting/dining area within a multi-bed complex is desirable. (HBN 21, para. 3.104)

MATERNITY DEPARTMENT

5 ORGANISATION OF SERVICE
5.7 CATERING

Earlier decision	Ref	
	A	Meals will be distributed by: (a) tray service [ ] (b) bulk food to ward/unit [ ] (c)
12B	B	Mothers will eat: (a) within a sitting/dining area within the multi-bed complex [ ] (b) in a separate sitting/dining area [ ] (c)
	C	Beverages and light snacks needed for mothers will be prepared: (a) in a ward pantry [ ] (b) in a pantry shared between two wards [ ] (c) in a small ward kitchen [ ] (d)
	D	Food/drink for women in labour will be: (a) light meals prepared in the department [ ] (b) kept warm at a central delivery suite beverage point [ ] (c)
12F	E	Food/drink for parents suite in neonatal unit will be: (a) provided from the antenatal/postnatal ward trolley [ ] (b) available in the neonatal unit pantry [ ] (c) available in central restaurant [ ] (d) provided by self-catering facilities [ ] (e)
	F	The system for catering for staff will be: (a) main meals in central restaurant [ ] (b) beverages/light snacks in central restaurant [ ] (c) beverages at ward level [ ] (d) beverages/light snacks at ward level [ ] (e) cold drinks at ward level [ ] (f) hot and cold drinks in neonatal staff area [ ] (g)
	G	The washing up system will be: (a) central wash facilities [ ] (b) unit/ward wash up facilities [ ] (c) unit/ward wash up, beverage crockery only [ ] (d) disposable crockery/cutlery for selected cases (barrier nursing) [ ] (e)

Earlier decision | Ref | 5 ORGANISATION OF SERVICE
5.7 CATERING (contd.)

12F
19E

A Beverage points for visitors will be provided in the:
(a) maternity outpatient suite [ ]
(b) delivery suite [ ]
(c) ward areas [ ]
(d) neonatal unit [ ]
(e)

B Tea bar facilities for maternity outpatients suite will be sited:
(a) in the clinic waiting area [ ]
(b) in the nearby general OPD waiting area [ ]
(c)

C Baby feeds will be prepared:
(a) by bulk preparation - commercial [ ]
(b) with disposable bottles [ ]
(c) with disposable teats [ ]
(d) by bulk preparation on site in a milk kitchen [ ]
(e) with non disposable bottles [ ]
(f) with non disposable teats [ ]
(g) in the neonatal unit (for selected babies) [ ]
(h) in the pharmacy (for selected babies) [ ]
(j) in the human milk bank [ ]
(k)

D Baby feeds will be stored in:
(a) bulk in the catering dept./the stores dept.(commercial feeds only) [ ]
(b) postnatal wards [ ]
(c) neonatal wards [ ]
(d) a central milk kitchen [ ]
(e) a human milk bank [ ]
(f)

5 ORGANISATION OF SERVICE
5.8 SUPPLY AND STORAGE

Goods are normally delivered to the department at the following frequencies, although this varies according to whole hospital policy:

Sterile supplies	- daily (6 times per week)
Linen supplies	- daily (6 times per week)
Pharmacy supplies	- daily (6 times per week)
Bulky disposables	- 3 times per week
Catering provisions - milk	- daily
- bread	- daily
- other	- weekly
Surgical dressings	- weekly
Syringes	- weekly
Cleaning materials	- weekly
Hardware and crockery	- fortnightly
Stationery	- fortnightly
Catering	- plated meal system
	- beverages made and served in the ward
Baby feeds - (commercially prepared)	- weekly
- (pharmacy prepared)	- daily

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.8 SUPPLY AND STORAGE

A Supply deliveries to be controlled by a topping-up system will be:

		No. of days stock	Frequency of delivery
	(a) sterile supplies		
	(b) linen		
	(c) pharmacy supplies		
	(d) medical and surgical sundries		
	(e) cleaning materials		
	(f) hardware and crockery		
	(g) stationery		
	(h) catering provisions - milk		
	(j) catering provisions - dry goods		
20C,D	(k) bulk disposables		
	(m) baby feeds (commercially prepared)		
	(n)		

B Supply deliveries to be controlled by a requisition system will be:

		No. of days stock	Frequency of delivery
	(a) sterile supplies		
	(b) linen		
	(c) pharmacy supplies		
	(d) medical and surgical sundries		
	(e) cleaning materials		
	(f) hardware and crockery		
	(g) stationery		
	(h) catering provisions - milk		
	(j) catering provisions - dry goods		
20C,D	(k) bulk disposables		
	(m) baby feeds (commercially prepared)		
	(n)		

C Controlled drugs, pharmacy supplies, medicines, etc. will be stored:
(a) in a clean utility area [ ]
(b) at the staff base in the ward [ ]
(c) in the charge nurse's/sister's office [ ]
(d) in anaesthetic rooms [ ]
(e) at the staff base in the delivery suite [ ]
(f) at the staff base in the neonatal unit [ ]
(g)

Sterile Supplies Store/Preparation Room

Sterile packs and lotions are kept here and the trolleys may be 'set up' in this room. A heated lotion cupboard is required.
(HBN 21, para. 3.75)

Emergency Obstetric Store

An emergency obstetric (flying squad) store may be required.
(HBN 21, para. 3.80)

Transport Incubator Bay

In a unit providing a paediatric flying squad all the equipment necessary must be readily available to the staff who may travel out, and an area in the unit must be available to store this equipment.
(HBN 21, para. 3.158)

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.8 SUPPLY AND STORAGE (contd.)

A The arrangement for clean utility in the delivery suite will be:
(a) main clean utility in normal delivery area [ ]
(b) small clean utility to service abnormal delivery/theatre area [ ]
(c)

B The method of linen supply will be:
(a) exchange trolley to each unit [ ]
(b) exchange trolley to each sub-unit [ ]
(c) mini exchange trolley topped up from exchange trolley [ ]
(d) topped up storage [ ]
(e)

C Dressings, sundries and sterile supplies will be stored in a:
(a) clean utility room [ ]
(b) supply store [ ]
(c)

D Facilities for the emergency obstetric unit (maternity flying squad) will be:
(a) in the delivery suite [ ]
(b) in the maternity department [ ]
(c) in the accident and emergency department [ ]
(d)

E Facilities required for the emergency obstetric unit will include:
(a) a refrigerator [ ]
(b) emergency blood supplies [ ]
(c) drugs [ ]
(d)
(e)

F Facilities for the neonatal flying squad will be:
(a) in the neonatal unit [ ]
(b) shared with the maternity flying squad in the delivery suite [ ]
(c) in the maternity suite [ ]
(d)

G Facilities required for the neonatal flying squad will include:
(a) transport incubator [ ]
(b) resuscitation equipment [ ]
(c) drugs [ ]
(d)

Control of Infection

Regard must be had to the District policy for the care of mothers and babies requiring source and protective isolation. No arrangements for such isolation have been incorporated in the Building Note.

It is expected that sufficient rooms with ensuite sanitary facilities will be provided in the delivery suite and the antenatal/postnatal ward accommodation for segregation and care of potentially/actually infected mothers, with or without their babies beside them.

Prevention of infection involves the consideration of the neonatal unit's design. It is important that there is adequate space within that unit to avoid overcrowding. Smooth surfaces with coved junctions and avoidance of dust traps help to prevent infection and are easy to keep clean.
(HBN 21, paras. 2,31, 2.32 and 2.33)

MATERNITY DEPARTMENT

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.9 DISPOSAL AND USED ITEMS

A The system of disposal will be:

(a) soiled linen in bags, colour coded _____

(b) infected linen in bags, colour coded _____

(c) soiled dressings in bags, colour coded _____

(d) returnable items to CSSD in bags, colour coded _____

(e) waste for disposal in bags, colour coded _____

(f) sharps for disposal in safety containers (type) _____

(g) contaminated crockery/cutlery in bags, colour coded _____

(h) labelled containers for CSSD items and pathology specimens [ ]

(j) returnable empties in labelled containers [ ]

(k)

B Soiled items of linen will be collected (SPECIFY FREQUENCY) from:

	Clinics	Wards	Delivery Suite	NNU
(a)	____	____	____	____
(b)	____	____	____	____
(c)	____	____	____	____

C Soiled dressings will be collected (SPECIFY FREQUENCY) from:

	Clinics	Wards	Delivery Suite	NNU
(a)	____	____	____	____
(b)	____	____	____	____
(c)	____	____	____	____

D Soiled returnable instruments will be collected (SPECIFY FREQUENCY) from:

	Clinics	Wards	Delivery Suite	NNU
(a)	____	____	____	____
(b)	____	____	____	____
(c)	____	____	____	____

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.9 DISPOSAL AND USED ITEMS (contd.)

A The arrangement for utility facilities in the delivery suite will be:
(a) main dirty utility in normal delivery area [ ]
(b) satellite utility areas in normal delivery rooms [ ]
(c) small dirty utility to service abnormal delivery area and operating theatre [ ]
(d) small dirty utility to service abnormal delivery area [ ]
(e) small dirty utility to service operating theatre [ ]
(f)

B Placentae will be examined, weighed and measured in:
(a) the main dirty utility [ ]
(b) a satellite dirty utility [ ]
(c)

C Sanitary items used in ward areas which will be disposable are:
(a) bed pans [ ]
(b)

D Bedpans/bedpan holders in ward areas and delivery suite will be kept in:
(a) the dirty utility room [ ]
(b)

E Sterilization of empty bottles and/or teats for baby feeds will be undertaken (SPECIFY METHOD):
(a) in the milk kitchen _____
(b) in CSSD _____
(c) in the ward areas _____
(d) at the bedside _____
(e)

F Hand drying in WC facilities will use:
(a) disposable towels [ ]
(b) non-disposable towels (supplied by hospital) [ ]
(c) non-disposable towels (supplied by outside contract) [ ]
(d) hot-air hand drying system [ ]
(e)

Telephones

Central telephone facilities for internal and external calls will normally be available and should be extended to serve this department in accordance with the requirements shown on the Activity Data Sheets. Telephones will normally be of desk pattern.

Guidance concerning the provision of telephone systems and equipment including the telephone internal cabling distribution and telephone hand sets, is given in HBN 48 (in preparation).

In addition to the above facilities, outlets should also be provided for coin box telephones, either of the fixed or trolley pattern as appropriate, in accordance with the requirements shown on the Activity Data sheets. All such equipment should be connected direct to the public network by separate exchange circuits and not routed via the hospital switchboard. It is also recommended that all terminations provided for connecting a particular trolley phone be wired to a common exchange circuit, as far as is practicable, in order to economise on the number of exchange lines allocated to this facility. (HBN 21, paras. 4.89, 4.90 and 4.91)

Patient/staff call system

Call points locations are indicated on the Activity Data sheets. A visual and audible indication of operation should be provided at the staff base and repeated at other appropriate points to give responding staff unambiguous identification of the call source. Guidance concerning the provision of patient/staff call systems is given in HTM15. Guidance concerning bedhead units for patient/staff call systems is given in Engineering Data Sheet DU3.1. (HBN 21, para. 4.87)

Staff location

The staff location system employed in the hospital should be extended to give adequate cover to this department. Guidance on these systems is given in HTM 20. (HBN 21, para. 4.88)

Wireways for Data Links

Wireways, which should be segregated from both the electrical power and the telephone internal cabling distribution systems, will usually be required for computer links between the main hospital computer system and the reception counter in the outpatient suite and the staff bases in the delivery suite, wards and neonatal unit. (HBN 21, para. 4.92)

Medical monitoring facilities

Wireways for medical monitoring equipment are to be provided in the delivery suite and the neonatal unit. Details of the areas to be served are set out on the Activity Data sheets. (HBN 21, para. 4.97)

Engineering Services

Services should be provided to the standards recommended in the Building Notes.

The Activity Data ("A" sheets) give details of the space heating and hot water temperatures, ventilation notes (including air conditioning for the operating suite and neonatal unit), illumination requirements and noise criteria. The corresponding Activity Data "B" sheets give details of the service positions for hot and cold water, electrical socket outlets, medical gases (oxygen, nitrous oxide, vacuum and compressed air), patient/staff and staff/staff call points and telephone points.

Earlier decision | Ref

5 ORGANISATION OF SERVICE
5.10 COMMUNICATIONS AND OTHER ENGINEERING SERVICES

A The telephone system will be:
(a) appropriate PABX system with suitable barring (as whole hospital) [ ]
(b) appropriate PABX system with satellite switchboard [ ]
(c) direct dialling in (DDI) to delivery suite [ ]
(d) direct dialling in (DDI) to outpatients [ ]
(e)

NB: DDI can only be provided if hospital exchange equipment and local public telephone network is available for this arrangement.

B Staff call facilities will be provided at:
(a) each bed [ ]
(b) all delivery rooms [ ]
(c) day/dining rooms [ ]
(d) bathrooms/showers [ ]
(e) WCs [ ]
(f) within reach of each cot [ ]
(g)

C Staff location will be via:
(a) pocket receivers to all essential staff [ ]
(b) cardiac arrest alarm connected to whole hospital emergency alarm [ ]
(c) other emergency arrangements (SPECIFY) _____

_____

(d)

D Wireways for computer data links will be provided from:
(a) the hospital main computer [ ]
(b) elsewhere (SPECIFY) _____
(c)

E And these will be linked to:
(a) reception in the outpatients suite [ ]
(b) staff base in the delivery suite [ ]
(c) staff base in the ward(s) [ ]
(d) staff base in the neonatal unit [ ]
(e)

6 GENERAL DESIGN REQUIREMENTS FOR THE DEPARTMENT

Earlier decision	Ref	6 GENERAL DESIGN REQUIREMENTS FOR THE DEPARTMENT
		The following general design requirements supplement the specific requirements stated in the other sections of this document and the "A" sheets.
21, 23A	A	The Maternity Department should have an external entrance for the outpatient suite and a route for supplies and collection of waste which does not pass through clinical areas.
2A, 5	B	If the department is not fully integrated in the district hospital, it will require its own main entrance in addition.
	C	The accommodation should be arranged to permit natural lighting and ventilation to all rooms occupied by patients or staff.
	D	The layout of the delivery suite should follow the natural progression from the entrance/assessment/reception area to normal or abnormal delivery rooms or operating theatre and recovery room.
	E	The delivery room which is sound-proofed should be sited near the high dependency area away from the activity in the normal delivery area.
5B	F	All antenatal and postnatal beds should be grouped on one or two floors with the exception of one high dependency area which could be sited in the delivery suite.
	G	Accommodation for babies must be sited so as to be easily visible from the staff base.
5	H	In hospitals undertaking neonatal surgery these may benefit if the surgical unit is sited near enough to the neonatal unit so they can share common facilities and skilled staff.
	J	The isolation/segregation section must have access and egress via (SPECIFY MEANS OF DOORS) _____

DESIGN BRIEFING SYSTEM

PART 2

This part of the document should be used when all the decisions in Part 1 have been completed, to select and record suitable activity spaces for the project. Whilst an activity space can be equated with a room, it may also be an unenclosed space such as a bay or corridor.

It is recommended that a sub-group of the planning team should select the activity spaces and related data sheets outside the main meeting so that sufficient time is available to thoroughly check the implication of planning decisions taken in Part 1.

COMPLETING PART 2

The activity spaces likely to be required have been divided into suitable groups of accommodation (eg SANITARY FACILITIES). References are provided in the "Earlier Decisions" column to decisions in Part 1 which may have an effect on the activity space chosen. Activity spaces are selected using the existing bank of Department of Health activity data sheets ("A" sheets), which may require modification to suit particular projects, or new "A" sheets may be generated.

The reference letter and number of "A" sheets, from which a choice may be made, should be recorded in the column (eg Disposal - Y0603). The number of activity spaces required should be entered in the "No." column. The "locational relationship" column should be used to state any important locational relationships within the department, either by ticking those already entered or adding new statements.

When all activity spaces have been chosen for each group, the whole of Part 2 should be reviewed, in its entirety, to enable the planning team to rationalise any over-provision or reconsider areas that may be shared, eg sharing of facilities between sections or sub-departments.

The schedule of activity spaces and data sheets may be typed directly from the completed Part 2, including any guidance the team may decide to include to assist designers.

DESIGN BRIEFING SYSTEM

MATERNITY DEPARTMENT

PART 2

SCHEDULE OF ACTIVITY SPACES

The accommodation to be provided in the Maternity Department is scheduled in the following group of accommodation:

	Page
OUTPATIENTS SUITE	29
DELIVERY SUITE	30
OPERATING SUITE	31
WARD UNIT	32
NEONATAL UNIT	33

Planning unit/dept	Page	Design Briefing System
MAT	29	MATERNITY DEPARTMENT

Decisions

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
2		OUTPATIENTS SUITE			
7,8,9	A	RECEPTION/RECORDS		J0419	
10C,13,14	B	WAITING/EDUCATION/PLAY AREAS		J1404	
13C	C	SUB WAITING		J1202	
	D	W.C.		V1106	
13G	E	SPECIMEN W.C./WHEELCHAIR W.C.		V1406	
10F,11B	F	CONSULTING/EXAMINATION ROOM		C0215	
	G	CLEAN UTILITY		T0504	
13G	H	DIRTY UTILITY		Y0409	
14E,15B	J	OFFICE		M0201	
17E	K	CLEANERS' ROOM		Y1501	
	L	EQUIPMENT STORE		W1605	
13D	M	PARENTCRAFT STORE		W1606	
23	N	DISPOSAL ROOM		Y0603	
21,22	O	LINEN STORE		W1401	
	P	SWITCH ROOM		K0101	
	Q	ULTRASOUND ROOM		E0112	
	R	VENEPUNCTURE ROOM (ECA)		C1407	
	S	SNACK BAR AND STORE (ECA)		F0305	
	T	TREATMENT ROOM (OAs)		X0107	
	U	STAFF CLOAKROOM (OAs)		V0420 V0421 V1005	

Planning unit/dept	Page	Design Briefing System
MAT	30	MATERNITY DEPARTMENT

Decisions

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
		DELIVERY SUITE			
12F	A	WAITING AREA		J1308	
	B	VISITORS' W.C.		V1106	
	C	TROLLEY/WHEELCHAIR PARK		G0110	
5D,5E,6	D	DELIVERY ROOM		B1001	
12D	E	PATIENTS' SHOWER/WC/UTILITY		V1615	
12B	F	SITTING ROOM		D1201	
	G	BLOOD BANK/BLOOD GAS ANALYSIS		L0501	
22A	H	CLEAN UTILITY		T0501	
24A,B,C,D	J	DIRTY UTILITY		Y0304	
9F,21C	K	STAFF BASE		T0117	
	L	PANTRY/BEVERAGE POINT		P0611	
15B,C	M	OFFICE		M0201	
4A,18E	N	SEMINAR/STAFF ROOM		D0406	
18C,D	O	MALE STAFF CHANGE		V0416	
18C,D	P	FEMALE STAFF CHANGE		V0422	
	Q	STAFF W.C.		V1005	
	R	STAFF SHOWER		V1605	
21C	S	EQUIPMENT STORE		W1609	
	T	LINEN BAY		W1602	
	U	DRY STORE		W1423	
17E	V	CLEANERS' ROOM		Y1503	
23	W	DISPOSAL ROOM		Y0605	
	X	SWITCH ROOM		K0101	

Planning unit/dept	Page	Design Briefing System	Decisions
MAT	31	MATERNITY DEPARTMENT	

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
		OPERATING SUITE			
3A	A	RECEPTION LOBBY		J0113	
6D,	B	ABNORMAL DELIVERY ROOM		B1102	
6D	C	OPERATING THEATRE		N0105	
21C,	D	ANAESTHETIC ROOM		N0302	
	E	THEATRE PREPARATION/SUPPLY		W1607	
	F	SCRUB-UP BAY		N0201	
24A	G	DIRTY UTILITY		Y0410	
18C,D	H	STAFF CHANGING (M)		V0514	
18C,D	J	STAFF CHANGING (F)		V0514	
	K	STAFF W.C./SHOWER		V1309	
	L	RECOVERY AREA		B2409	
	M	DOCTORS OFFICE/OVERNIGHT STAY (ECA)		M0902	
	N	INTERVIEW/EXAMINATION ROOM (OAs)		C0507	
	O	ENSUITE FACILITIES FOR INTERVIEW/ EXAMINATION ROOM (OAs)		V1719	
	P	EMERGENCY OBSTETRIC STORE (OAs)		W1603	

Planning unit/dept	Page	Design Briefing System
MAT	32	MATERNITY DEPARTMENT

Decisions

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
6		WARD UNIT			
	A	6 BEDDED ROOM		B0805	
	B	6 BEDDED ROOM (ADDITIONAL CARE)		B0901	
	C	4 BEDDED ROOM		B0806	
	D	SINGLE BED ROOM		B0807	
12D	E	SINGLE BED WITH WC/SHOWER		B0808	
21C	F	CLEAN UTILITY		T0601	
24A,24B, 24D,13G	G	DIRTY UTILITY		Y0310	
19C,19E	H	PANTRY		P0603	
12B	J	DAY SPACE		D0807	
	K	STAFF BASE		T0117	
15A,B,C	L	SISTER'S OFFICE		M0201	
12D	M	WC/WASH/SHOWER		V1612	
	N	ASSISTED BATHROOM		V1723	
13G	O	SPECIMEN WC		V1407	
12D	P	BATHROOM		V1707	
	Q	FLOWER BAY		Y1402	
22D-G	R	EQUIPMENT PARKING		G0111	
12G	S	INTERVIEW ROOM/DOCTOR'S OFFICE		M0201	
21,22B	T	LINEN ROOM		W1422	
	U	SWITCH ROOM		K0101	
23,24	V	DISPOSAL ROOM		Y0605	

Decisions

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
		WARD UNIT (contd)			
	A	DRY STORE		W1423	
	B	EQUIPMENT STORE		W1424	
	C	DAY ROOM (ECA)		D1110	
	D	SEMINAR ROOM (ECA)		D0406	
	E	CONSULTING/EXAMINATION ROOM (ECA)		C0215	
	F	MILK/KITCHEN STORE (ECA)		P1003	
	G	CLEANERS' ROOM (ECA)		Y1207	
	H	2-COT NURSERY (ECA)		B1203	
	J	STAFF CHANGING - MALE (OAs)		V0420	
	K	STAFF CHANGING - FEMALE (OAs)		V0421	
		NEONATAL UNIT			
	L	SINGLE NURSERY		B1401	
	M	4-COT NURSERY		B1402	
	N	6-COT NURSERY		B1403	
	O	STAFF BASE		T0116	
	P	UTILITY ROOM		Y0504	
	Q	EQUIPMENT STORE		W1608	
	R	BEVERAGE POINT		P0702	
	S	SISTER'S OFFICE		M0201	
	T	LINEN BAY		W1602	

Decisions

Earlier decision	Ref	Activity Space	No.	A sheet	Locational relationship
		NEONATAL UNIT (contd)			
	A	FEMALE STAFF WC		V0902	
	B	FEMALE STAFF CHANGING		V0423	
	C	MALE STAFF WC		V0901	
	D	MALE STAFF CHANGING		V0424	
	E	STAFF SHOWER		V1614	
	F	CLEANERS' ROOM		Y1501	
	G	DISPOSAL ROOM		Y0605	
	H	SWITCH ROOM		K0101	
	J	VISITORS DAY/PLAY ROOM		D1401	
	K	LABORATORY		L1303	
	L	MILK KITCHEN		P1004	
	M	SEMINAR ROOM		D0406	
	N	PARENTS' BED ROOM (ECA)		D1502	AND D1503
	O	PARENTS' SHOWER (ECA)		V1605	
	P	PARENTS' WC (ECA)		V1106	
	Q	TRANSPORT INCUBATOR BAY (ECA)		W1610	
	R	OFFICE (ECA)		M0201	
	S	DOCTORS OFFICE/OVERNIGHT STAY (ECA)		M0902	
	T	MILK BANK (OAs)		P1005	
	U	PARENT/VISITOR BATH ROOM (OAs)		V1721	

2 SCOPE OF SERVICE AND WORKLOAD (contd)

PLEASE REFER TO THE POLICY STATEMENT IN MSAC III, PARAS. 4.1 AND 4.2 FOR SERVICES FOR SMALL AND ILL BABIES

Accommodation
A mother with a condition which requires specialist treatment should be cared for within the maternity unit unless intensive care facilities or other specialist care are essential.
(MSAC III, para. 3.10)

Provision of intensive care
Within each region there will be a need for one or more designated Regional Perinatal Centres, able to maintain care for the mother and intensive care for the baby for long periods. Mothers can be referred antenatally to such units when the birth of a baby who is likely to require long term intensive care is anticipated. All but the smallest maternity units should have their own neonatal unit with staff able to initiate intensive care for very small and ill babies whenever required, and to maintain such care at least until the baby can be transferred to a unit with the necessary facilities.

The function of Regional Perinatal Centres should be to provide the necessary back-up to Districts and to take the lead in training medical and nursing staff in the high level of expertise required and in research directed towards advancing standards and effectiveness of perinatal care.

A Regional policy of total centralisation of neonatal intensive care in Regional Perinatal Centres is not recommended. This creates difficulties in maintaining family links. District neonatal units need moreover to develop in parallel with Regional Centres their ability to provide some intensive care because anticipation, prompt recognition and early intervention in neonatal disorders may prevent deterioration and so will minimise the need to transfer the baby elsewhere.
(MSAC III, paras. 4.4, 4.5 and 4.6)

The neonatal unit
The term 'neonatal unit' is used to describe any area designated for small or ill babies who cannot be cared for with their mothers in the areas for postnatal care. All babies needing intensive care will be admitted to such a unit, together with a proportion of those needing special care. As staffing levels and expertise build up however, more babies can be expected to receive appropriate forms of special care not in the unit, but with their mothers in the postnatal areas. The extent of the need for special care in neonatal units will depend on the one hand on the ability to care for babies in the postnatal area, and on the other on the number of babies who progress to special care from intensive care.
(MSAC III, para. 4.3)

Neonatal units for small and ill babies
An area within the DGH maternity department should be designated for neonatal intensive care and/or for special care for those babies not able to be cared for alongside their mothers.

Most DGHs will be expected to provide a measure of intensive care as facilities and expertise develop outwards from the Regional Perinatal Centres. If a maternity department has no long-term intensive care facilities, certain babies will need to be transferred to Regional Perinatal Centres or other specialised units.
(HBN 21, para. 2.22)

Provision for neonatal surgery
The Regional strategy should include provision for neonatal surgery. Babies requiring immediate surgery to correct a life threatening condition should be admitted without delay to a special neonatal surgical unit. Ideally, such facilities should be sited within Regional Perinatal Centres. There should be at least one such unit in each Region able to provide continuous care and supervision of the baby by medical and nursing staff before and after the operation, although for neonatal cardiac surgery referral may have to be to a designated Supra-Regional Centre. (MSAC III, para. 4.10)

Earlier decision | Ref

2 SCOPE OF SERVICE AND WORKLOAD (contd.)

A Operating theatre facilities will be available:
(a) in the delivery suite [✓]
(b)

B Mothers requiring intensive or specialised medical care will be cared for in:
(a) the maternity unit [✓]
(b) the DGH [ ]
(c)

C Babies requiring intensive neonatal care will be cared for:
(a) in the neonatal unit [✓]
(b) by short term support, then transferred elsewhere and returned for subsequent care [ ]
(c)

D Babies requiring neonatal surgery will be cared for in:
(a) the neonatal unit [ ]
(b) the paediatric department [✓]
(c) another hospital (SPECIFY) _____
(d)

E A segregated nursing area will be required for:
(a) mothers with infections, with or without babies [✓]
(b) babies with infections, accompanied by their mothers [✓]
(c) babies with infections [ ]
(d)

F Cases of major infection, where the infection takes precedence over the obstetric condition, will be nursed in:
(a) an isolation unit [✓]
(b)

EXAMPLES OF WAYS IN WHICH A SECTION OF A BRIEF COULD BE TYPED FROM THE OPTIONS PAGE ABOVE

Options selected - typed directly from DBS page 3

2. SCOPE OF SERVICE AND WORKLOAD (contd.)

A. Operating theatre facilities will be available:
(a) in the delivery suite

B. Mothers requiring intensive or specialised medical care will be cared for in:
(a) the maternity unit

C. Babies requiring intensive neonatal care will be cared for:
(a) in the neonatal unit

D. Babies requiring neonatal surgery will be cared for in:
(b) the paediatric department

E. A segregated nursing area will be required for:
(a) mothers with infections, with or without babies
(b) babies with infections, accompanied by their mothers

F. Cases of major infection, where the infection takes precedence over the obstetric condition, will be nursed in:
(a) an isolation unit

Options selected - narrative form

2. SCOPE OF SERVICE AND WORKLOAD (Contd.)

Operating theatre facilities will be available in the delivery suite. 3A

Mothers requiring intensive or specialised medical care will be cared for in the maternity unit. 3B

Babies requiring intensive neonatal care will be cared for in the neonatal unit. 3C

Babies requiring neonatal surgery will be cared for in the paediatric department. 3D

A segregated nursing area will be required for mothers with infections, with or without babies, and babies with infections, accompanied by their mothers. 3E

Cases of major infection, where the infection takes precedence over the obstetric condition, will be nursed in an isolation unit. 3F

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